

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 04/18/03.

I. DISPUTE

Whether there should be reimbursement for CPT codes 95851, 97113, 97122, 99213-MP and 97750-FC for dates of service 07/09/02 through 11/11/02.

II. RATIONALE

- CPT code 95851 on dates of service 07/09/02 and 07/22/02. The respondent denied the service as “3-By clinical practice standards, this procedure is incidental to the related primary procedure billed”. The respondent does not specify what service CPT code 95851 is incidental to or how it is incidental to that service. The service will be reviewed per the 1996 Medical Fee Guideline. The Range of Motion reports for dates of service 07/09/02 and 07/22/02 support the delivery of service per Rule 133.307 (g)(3)(A-F). Reimbursement in the amount of \$72.00 is recommended.
- CPT code 97113 for date of service 07/10/02. The respondent denied the service as “1-(U) Manipulation and/or physical therapy not to exceed four a day”. The physical therapy session did not exceed the 4 procedure limit or the 2 hour limit per MFG I (10)(a). Reimbursement in the amount of \$156.00 (\$52.00 x 3 units) is recommended.
- CPT code 97122 for dates of service 07/10/02 and 07/16/02. The respondent denied the service as “1-(U) Manipulation and/or physical therapy not to exceed four a day”. The physical therapy session did not exceed the 4 procedure limit or the 2 hour limit per MFG I (10)(a). Reimbursement in the amount of \$70.00 (\$35.00 x 2 dates of service) is recommended.
- CPT code 99213-MP for date of service 07/10/02. The respondent denied the service as “2-(D) This item was previously submitted and reviewed with notification of decision issued to payer provider (Duplicate Invoice) and 3-(F) Manipulation”. The respondent did not submit HCFA or an EOB showing duplicate billing and/or payment made. Reimbursement in the amount of \$48.00 is recommended.
- CPT code 99213 for date of service 08/12/02. An EOB was not submitted by either party; therefore the service will be reviewed per the 1996 Medical Fee Guideline. S.O.A.P. notes for date of service 08/12/02 support delivery of service per TWCC Rule 133.307 (g)(3)(A-F). Reimbursement in the amount of \$48.00 is recommended.

- CPT code 97750-FC for date of service 11/11/02. The respondent denied the service as “1-Maximum number of units has been reached and 2-(F) Functional Capacity”. The summary of the carrier’s position statement further explained that the carrier’s records indicate that the claimant had FCE’s on 05/24/01, 06/21/01 and 07/27/01, therefore denied the charges per MFG Medicine GR I (E)(2). Testing reports were not submitted to substantiate this denial. The Functional Capacity Evaluation report for 11/11/02 supports the delivery of service per TWCC Rule 133.307 (g)(3)(A-F). Reimbursement in the amount of \$300.00 (\$100.00 x 3 hours) is recommended

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement in the amount of **\$694.00**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **\$694.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 12th day of February 2004.

Laura L. Campbell
Medical Dispute Resolution Officer
Medical Review Division

LLC/lc